TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Universal DME LLC

**Respondent Name**
Allmerica Financial Benefit Insurance Company

**MFDR Tracking Number**
M4-16-3729-01

**Carrier's Austin Representative**
Box Number 1

**MFDR Date Received**
August 17, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "HCPCS Code E0217 was denied on 03/31/2016. Per EOB the code was for a cold unit and we had E0217 which was for a hot unit, we changed the code and sent in the appeal. On 04/04/2016 we sent an appeal for payment, and on 04/27/2016 the appeal was paid partially in the amount of $45.06."

**Amount in Dispute:** $507.94

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary**: "The submitted code will be considered as a monthly rental. Because this service is reimbursable per month rather than per day the allowed number of units will be one. The requestor's position is not supported."

**Response Submitted by:** CorVel Healthcare Corporation, 10000 North Central Expressway, Ste 300, Dallas, TX 75231

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 26, 2016 through February 1, 2016 | E0218 -RR | $507.94 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- RR – Rented Equipment
- RA6 – Procedure Billing Restricted/Once per 30 days

**Issues**

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The service in dispute is HCPCS Code E0218 – "Water circulating cold pad with pump." The health care provider added the "RR" modifier to indicate rental of the durable medical equipment.

   The requestor is seeking additional reimbursement in the amount of $507.94. The carrier made a payment of $45.06 and explained this reduction as "P12-Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Labor Code §134.203(d) states in pertinent parts,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
   >
   > (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS;

   Review of the 2016 1st Quarter Texas DMEPOS Fee Schedule found at www.cgs.medicare.com, shows no fee schedule allowable for code E0218. Therefore, there is no Medicare published rate under DMEPOS.

   Because there is no published rate under Medicare DMEPOS, the Division looks to the Texas Medicaid fee schedule found at www.tmhp.com as described under §134.203(d)(2) above.

   Texas Medicaid indicates that a rental for code E0218 has a total allowable of $36.05.

   Therefore, per 28 Texas Labor Code 134.203(d)(2), the applicable fee schedule amount is $36.05. This amount multiplied by 125% = $45.06

2. The maximum allowable for the services in dispute is $45.06. The carrier previously paid $45.06. No additional payment is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | October 13, 2016<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.